SBIRT: Screening, Brief Intervention and Referral to Treatment

Using an Integrated Behavioral Health Model to Reduce and Prevent Substance Use
Montana Healthcare Foundation

• The Montana Healthcare Foundation (MHCF) makes strategic investments to improve the health and wellbeing of all Montanans

• MHCF supports:
  • Access to quality and affordable health services
  • Conducting evidence-driven research and analysis
  • Addressing the upstream influences on health and illness
Integrated Behavioral Health (IBH) and SBIRT

• *Integrated behavioral health* (IBH) is the term used for providing patients with coordinated physical and behavioral health care

• Individuals struggling with mental illness or substance use disorders are often at greater risk for chronic health issues and coordinating care can help improve health

• SBIRT is a part of an IBH model

• MHCF supports SBIRT implementation:
  • IBH Initiative
    • 60+ Grantee Sites
    • School-based Health Centers
  • Perinatal Behavioral Health Initiative (PBHI)
    • 11 Grantee Sites
Overview of Presentation

• Integrated Behavioral Health (IBH)
  • Holly Schleicher, University of Montana

• Screening, Brief Intervention and Referral to Treatment (SBIRT)
  • Michele Henson, Montana Healthcare Foundation

• Questions and Answers

• SBIRT with Pregnant Women: Perinatal Behavioral Health Initiative
  • Jennifer Rieden, Department of Public Health and Human Services
  • Sara Boutilier, Department of Public Health and Human Services

• SBIRT with Adolescents: School-based Health Centers
  • Michele Henson, Montana Healthcare Foundation

• Questions and Answers
INTEGRATED BEHAVIORAL HEALTH

HOLLY SCHLEICHER, PHD
DIRECTOR OF INTEGRATED BEHAVIORAL HEALTH
CLINICAL ASSISTANT PROFESSOR, THE UNIVERSITY OF MONTANA
Definition of Integrated Care
The **why** of Integrated Behavioral Health
The **what** of Integrated Behavioral Health
Overview of the Behavioral Health Consultant model and **How** it works
Research Evidence for IBH
INTEGRATED BEHAVIORAL HEALTH: DEFINITION

“A practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

This care may address mental health and substance abuse conditions, health behaviors (incl. their contribution to chronic medical illness), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization”

“I’ve asked her to go to counseling a number of times, she only wants to see me.”

“He dropped out of counseling due to financial and transportation issues.”

“She’d never see someone for her ‘mental’ health.”

Ability to see patients that I’d never see

Ability to work collaboratively

Ability to address health-related behaviors
INTEGRATION: THE WHY

- Rooted in the **Biopsychosocial** model
  - Proposed approximately 40 years ago (Engel, 1977)
- Primary Care is “**De Facto**” Mental Health System (Kessler & Stafford, 2008)
  - 43-60% of patients with psychological problems are solely treated in PC
    - Compared to 17-20% treated in specialty mental health
  - Less than 1/3 of referrals to specialty mental health are completed (Miranda et al., 1994)
    - Mental Health Stigma
    - Most patients prefer to be treated in primary care
INTEGRATION: THE WHY

MENTAL HEALTH TREATMENT PATHWAYS

Visits for Individuals with Poor Mental Health

49%  Primary Care Only
18%  No Visit
14%  Primary Care + Mental Health
14%  Other Combo
5%   Mental Health Only

Findings from 109,593 respondents to the 2002-2009 Medical Expenditure Panel Surveys (MEPS)

INTEGRATION: THE WHY

- Primary Care is “De Facto” MH System cont.
  - High prevalence of medical and psychiatric comorbidities
    - 68% of adults with a mental illness have one or more chronic physical condition
    - Depression, anxiety, panic, somatization, and substance use
    - Half of patients presenting to PC found to have no medical illness
  - Implications for diagnosis, compliance, and utilization
    - Formal diagnosis rarely made; accurate depression diagnoses in 14-50% of cases
    - Less than half of patient comply with pharmacologic treatment for the therapeutically indicated period of time
Co-occurrence between mental illness and other chronic health conditions:

- **High Blood Pressure**: 21.9% with mental illness, 18.8% without mental illness
- **Smoking**: 36% with mental illness, 21% without mental illness
- **Heart Disease**: 5.9% with mental illness, 4.2% without mental illness
- **Diabetes**: 7.9% with mental illness, 6.0% without mental illness
- **Obesity**: 42% with mental illness, 35% without mental illness
- **Asthma**: 15.7% with mental illness, 10.6% without mental illness

https://www.integration.samhsa.gov/integrated-care-models/
Suicide Statistics (Luoma, 2002)

- Pts who die by suicide visit PCPs more than 2x as often as mental health clinicians
- 45% of suicide victims saw their PCP in the month before their death
- 20% of those dying by suicide saw a mental health professional
Social Determinants of Health (WHO)

- Lifestyle factors are 5X that of Healthcare factors
### Levels of Integration

<table>
<thead>
<tr>
<th>Coordinated</th>
<th>Co-located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal collaboration, siloed care</td>
<td>BHP on-site, BHP and PCP keep separate schedules, records, and treatment plans</td>
<td>Close collaboration, shared treatment plans and records, some joint visits on PCP schedule</td>
</tr>
<tr>
<td>Basic collaboration at separate locations</td>
<td>Some systems integration, BHP and PCP keep separate schedules, some shared treatment plans</td>
<td>Close collaboration, shared treatment plans and records, most appointments on PCP schedule</td>
</tr>
</tbody>
</table>

*Note: BHP = Behavioral Health Provider; PCP = Primary Care Provider*
INTEGRATION: THE WHAT

- Paradigm shift for both “houses” (medicine and mental health)
  - Referrals don’t work
  - Can’t bring traditional therapy model into PC
- Based on Population-based care
- Behavioral Health Consultant Model
  - Length of visits
  - Frequency of visits
  - Number of total visits
  - “Office” space
  - Communication

The SOLUTION

The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services. Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.
INTEGRATION: THE WHAT

WHAT IT IS NOT

- Just collocation and consultation
- Shared records but no treatment integration
- Compartmentalization
  - “This part is your job and this part is my job”
- Referral system via computer
- Basic case management
  - “Here is a resource guide”
- Warm handoff for appointment another day
  - “I don’t have time for a warm handoff, so just have them schedule an appointment for next week”
- Long-term, 60 min sessions

WHAT IT IS

- True Team-Based Care
- Team Assessment
- Shared Care Plans
- Shared Accountability
- Real time collaboration w PCP & team members
- Continuum of care with inter-disciplinary team
- Brief consultation and/or Intervention: 30 minute sessions solution and symptoms focused (Treat to Target)
- Data Driven and Evidence Based; Universal screenings (MH SUD Trauma)
- Patient Centered and Patient Directed
Health Center

**PCP Duties:**
- Team leader
- Physical Exams
- Prescribing medications
- Treating/managing physical symptoms
- Set up physical treatment goals

**Behavioral Health Duties:**
- Screenings
- Address comorbid conditions
- Medication Management
- Real Time Collaboration
- Collaboration with Assessment
- Change Treatment if not Improving

- Identifying motivation to change health
- Provide skills to improve symptoms of targeted diagnoses
- Set Behavioral Health goals (treat to target)
- Identify outside factors contributing to health
- Identify resources
- Consulting
INTEGRATION: THE HOW

- Embedded BH provider in primary care
  - “co-location is relapse”
- Universal screening
- Huddles
- Scrubbing schedules
- Collaborative treatment plans (incl. mental health and recovery plans)
- Prescribing with psychiatric consultation
- Medication assisted treatment
BHC SERVICES

- Direct Clinical Services
  - Brief, evidence-based interventions during pt visits (Visits are 15-30 min); Group interventions
- Training/Impact on Team
  - Presentations at meetings (e.g., Motivational Interviewing, Trans-affirmative Care)
  - Educational flyers; Development of shared treatment plans
- Supporting the system
  - BHC follows up (less follow-up for PCP); See pts while they wait for PCP; Allows PCP to move onto the next patient
  - Tracking and follow-up; Review documents outside of the medical clinic
HOW THE BHC CAN BE USEFUL

- MH Concerns
  - Depression, anxiety, substance use, trauma, ADHD, panic, life stress/adjustment
  - Diagnosis, treatment monitoring
- Lifestyle management/Chronic Illness Conditions
  - DM, high BP, pain, asthma, tobacco use, obesity, sleep
- Treatment adherence
- Care across the lifespan
IBH FOR CHILDREN & FAMILIES

- Participation in well-child visits: Sleep, eating, toilet training, difficult emotions/behaviors, parenting/positive reinforcement/limit setting
- Mental Health in Youth: Mood disorders, ADHD, Suicide Risk and Assessment, Learning and School difficulties, Body Image, Trauma/ACES
- Social Relationships
- Perinatal screening and treatment
EVIDENCE

- Reduced costs
  - Decreased use of ED and admissions (Lute & Manson, 2015)

- Patient satisfaction
  - High levels of satisfaction and would seek it again in the future (Hunter, 2018)

- Provider satisfaction (Blount, 2003)
EVIDENCE

- Patient Outcomes
  - Improved Access (Landoll, 2018)
    - Increased patient encounters, expanded patient populations
  - Increase in Functioning (Hunter, 2018)
  - Symptom Improvement (Hunter, 2018)
    - Depression, anxiety, PTSD, sleep, and tobacco
REFERENCES AND RESOURCES


SBIRT: Screening, Brief Intervention and Referral to Treatment
Screening, Brief Intervention & Referral to Treatment (SBIRT)

• SBIRT is a part of an Integrated Behavioral Health Model
• SBIRT was developed for use by people who are working in non-SUD treatment settings and are not addiction specialists
• Primary care and emergency departents see more patients with behavioral health disorders than other providers

**Screening**
Quickly assess presence and severity of substance use & appropriate treatment

**Brief Intervention**
Increase awareness or use and motivation toward behavior change

**Referral to Treatment**
Provides those needing more extensive treatment with access to specialty care
Screening

- SBIRT begins by screening every patient for substance use
  - Goal: Identify risky use to prevent future use and reduce risky use

Screening Routine, Universal Screening of Patients

- No or Low Risk for Substance Abuse
- Moderate Risk for Substance Abuse
- High Risk for Substance Abuse
Once a year, we ask all our patients to complete this form on conditions that affect their health. Please help us provide you with the best medical care by answering the questions below.

Please circle the best response to each question.

### In the past 3 months...

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-4 times a month</th>
<th>2-3 times a week</th>
<th>4+ times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often did you have a drink containing alcohol?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol did you have on a typical day when you were drinking?</td>
<td>0</td>
<td>1 or 2 drinks</td>
<td>3 or 4 drinks</td>
<td>5 or 6 drinks</td>
<td>7, 8 or 9 drinks</td>
</tr>
<tr>
<td>3. How often did you have 5 or more drinks on one occasion?</td>
<td>0</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>4. How often have you used marijuana?</td>
<td>0</td>
<td>Not monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>5. How often have you used an illegal drug or a prescription medication for non-medical reasons*?</td>
<td>0</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
</tbody>
</table>

* if patient needs further explanation, “for example, for the feeling or experience it caused.”
Screening

Average screening results:

- No or Low Risk for Substance Abuse: 70%
- Moderate Risk for Substance Abuse: 25%
- High Risk for Substance Abuse: 5%
Brief Intervention

• A Brief Intervention is appropriate for those who screen at low to moderate risk

• Typically lasts between 5 to 15 minutes

• Goal: Motivate individuals to change their behavior
  • Provide information and feedback about screening results
  • Understand patient’s feelings about substance use and motivation to change
  • Provide clear, respectful professional advice about the need to reduce risky use by butting down or quitting
Brief Intervention

• Brief Interventions are not intended to treat people with serious substance dependence

• Most common therapies:
  • Brief version of cognitive behavioral therapy
  • Motivational interviewing
Brief Intervention

Brief Negotiated Interview:

1. Raise the subject
   - Ask about willingness to discuss screening results

2. Provide feedback
   - Review screening results; Show NIAAA Guidelines

3. Enhance Motivation
   - Discuss Pros and cons; Readiness to change

4. Negotiate and Advise
   - Make plan based on responses
Referral to Treatment

• A referral to treatment is appropriate for those who screen for substance use dependence or at high risk for dependence

• In an IBH model, a referral to treatment will involve:
  • A “warm handoff” to a specialty provider
  • Connection with a care coordinator to assist with accessing specialized treatment
Why implement SBIRT

• Nearly 90% of people who need SUD treatment do not receive it
• All 56 of Montana’s counties are designated as health professional shortage areas for mental health services
• Studies have shown SBIRT to be effective in reducing substance use
• SAMHSA study: SBIRT was associated with reduced substance use at 6-month follow-up:
  • Reduced alcohol use by 35%
  • Reduced heavy drinking by 43%
  • Reduced illicit drug use by 75%
Questions?
Perinatal Behavioral Health Initiative

Montana Healthcare Foundation (MHCF)/Montana Department of Public Health and Human Services (DPHHS) Partnership

August 2019
Introduction: Perinatal Behavioral Health Initiative Team

Montana Healthcare Foundation Staff:

- Tressie White
  - Program Director

- Kassie Runsabove
  - Program Officer

- Dr. Aaron Wernham
  - Chief Executive Officer

DPHHS Staff:

- Jennifer Rieden
  - Member Health Mgmt.
  - Bureau Chief

- Sara Boutilier
  - HRSA Perinatal BH Grant Coordinator
Scope of the Problem

- The number of Montana children in foster care has more than doubled since 2011; out of more than 3,200 children in foster care in 2016, 64% were removed from the home for reasons related to parental substance abuse.

- Among Medicaid patients, the percentage of infants with perinatal drug exposure increased from 3.7% in 2010 to 12.3% in 2016.

- Access to SUD treatment is a huge problem for pregnant women: as of 2016, only 6% of Montana’s state-licensed substance use disorder treatment programs served pregnant women or young families.

- Screening and treatment for prevalent mental illnesses are not yet routine in prenatal and post-partum care.

(Reference: Medicaid's Role in the Delivery and Payment of Substance Use Disorders, March 2017)
Impact of Perinatal Behavioral Health Issues

• Perinatal mood and anxiety disorders are associated with increased risks of maternal and infant mortality and morbidity.

• The impact of parental depression and anxiety, especially the mother, can be quite significant both on the attachment relationship and on the neurodevelopment of the baby. This impact is exacerbated when the parent experiences more clinically significant mental health issues, such as psychosis.

• Regular use of some drugs can cause neonatal abstinence syndrome (NAS).

• The type and severity of an infant’s withdrawal symptoms depend on the drug(s) used, how long and how often the birth mother used, how her body breaks the drug down, and whether the infant was born full term or prematurely.

• Parents are rightly and understandably fearful that seeking prenatal care, disclosing substance use, and initiating treatment for a Substance Use Disorder may result in harmful and punitive child welfare involvement.

   [This, unfortunately, increases the risk of obstetrical complications, preterm birth, and delivery of low birth weight infants. It also contributes to higher rates of unmanaged Neonatal Abstinence Syndrome (NAS)].
Is there any good news on this problem?

Yes: A simple set of clinical and community interventions can:

- Reduce the rate of drug positive newborns
- Reduce the rate of Neonatal Abstinence Syndrome (NAS)
- Reduce the need for foster care placement
- Improve maternal/family health and social outcomes
- Improve access to behavioral health services for pregnant women, and improve mental health and SUD-related outcomes
Integrated Care = Whole Person Care

Physical Health

Substance Use

Mental Health

[Diagram showing a pregnant woman connecting physical health, substance use, and mental health]
Integration: Why?

• Access: there will never be enough specialty providers/specialty care available for people who need it.

• Referrals by and large don’t work—at least the “cold” ones.

• Decrease patient burden, catches people where they are.

• Improved outcomes.

• Restores the mind/body connection.

• Decreases discrimination (stigma).
Perinatal Behavioral Health Initiative

Goal: Reduce the adverse outcomes of perinatal mental illness and substance use disorders for newborns and families, by implementing team-based integrated prenatal care in every Montana community with a delivering hospital.

History: In May 2018 MHCF and Montana Department of Public Health and Human Services announced the “Solving Perinatal Drug and Alcohol Use Initiative”. That initiative allows prenatal care providers to implement supportive, team-based care and better coordination between health care providers and social service agencies to address this drug and alcohol use in pregnancy.
MHCF partnered with DPHHS to apply for and be awarded a HRSA grant to expand the scope of the project and to jointly administer the project throughout the state of Montana.

**What’s new?** With the additional support from HRSA we have expanded the scope to add screening, treatment, and referral for mental illnesses such as depression and anxiety.

**What’s unchanged?** The clinical model stays the same—the core of this initiative is still integrated, team-based care with care coordination.
Initiative partners

- Governor’s Office
- Montana Healthcare Foundation
- Department of Public Health and Human Services
  - Medicaid
  - Child and Family Services
- National Council for Behavioral Health
- Organizations who provide prenatal services across the state
Clinical Team

- **Prenatal Care Providers**: Screen for SUDs, conduct brief interventions and "warm hand-offs".
- **Behavioral Health Provider**: Provide brief counseling interventions and outpatient therapy. Refer to higher-level care.
- **Care Coordinator**: Address social issues and coordinate referrals.
Perinatal Behavioral Health Initiative Grantees

- Community Hospital of Anaconda, Anaconda, MT
- St. Vincent’s Healthcare, Billings, MT
- Bozeman Health, Bozeman, MT
- Blackfeet Tribal Health, Browning, MT
- St. James Healthcare, Butte, MT
- Helena OBGYN & Assoc., Helena, MT
- Benefis Health System, Great Falls, MT
- St. Peter’s Health, Helena, MT
- Livingston HealthCare, Livingston, MT
- Community Medical Center, Missoula, MT
- Providence Montana Health, Missoula, MT
Funding Opportunity

- Grant funding of up to $150,000 (for each grantee site) for 2-year projects is available to support the development of the model.
- MHCF and DPHHS will also provide in-depth training and technical assistance to grantees throughout the project, in collaboration with the National Council for Behavioral Health.
- Grant funding will be awarded to providers who work closely with pregnant and postpartum mothers experiencing behavioral health issues. Family practitioners, obstetricians, midwives, and rural hospitals are encouraged to apply.
- Telehealth services to meet the needs of the grantees will be provided through the HRSA grant.
**Required Grant Elements**

- **Clinical Team:** Establish a care team that includes prenatal and post-delivery care with care coordination and "warm hand-offs" to a licensed behavioral health clinician located in the prenatal practice.

- **Community-Wide Reach:** Develop partnerships and a defined referral pattern among practices in the community so that most prenatal patients are screened for substance use disorders and those that need care are cared for by the clinical team.

- **Multidisciplinary Collaboration:** Develop collaborations among the clinical team, child protective services, public health and home visiting programs, criminal justice, and other agencies as appropriate.

- **Unmet Social Needs:** Screen for social needs and use care coordination and collaboration with local organizations to address needs such as transportation, housing, and additional intensive treatment.

- **Culture Change and Communications:** Develop and promote (both in the hospital and community) a supportive approach that engages women and increases participation in prenatal care and substance use disorder treatment.

- **SBIRT and Depression and Anxiety screening:** Implement screening for SUD and mental illness, along with brief intervention, and referral to treatment for pregnant women.

- **Collaboration with Tribes or Urban Indian Health Centers:** Develop a strong collaboration with the appropriate tribal or urban Indian health centers if caring for a substantial number of American Indian families.
Questions?

Thank you!

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SBIRT with Adolescents
SBIRT with Adolescents: SBIRT-A

• SBIRT-A is appropriate for adolescents aged 11 to 17 years old
• SBIRT-A: Works the same way as SBIRT with adults with a few adaptations
  • Screening:
    • Tool must be appropriate for adolescents
    • Caregivers may or may not need to be present
  • Brief intervention:
    • Recommend involving caregivers; some circumstances may require caregiver involvement
  • Referral to treatment:
    • Treatment must be appropriate for adolescent patients
SBIRT in School-Based Health Centers

• School-Based Health Centers provide a variety of health services to youth in or near a school

• Adolescents who have access to behavioral health services through a SBHC are:
  • More likely to access care
  • Less likely to report feelings of depression and suicidal ideation
  • Less likely to be absent from school
SBIRT in School-Based Health Centers

• MHCF is currently working several SBHCs to enhance their behavioral health services:
  • Alluvion Health Center (Great Falls)
  • Bighorn Valley Health Center (Ashland)
  • Fort Peck Health Promotion Disease Prevention (Poplar, Frazer, Wolf Point)
  • Northwest Community Health Center (Libby)
  • Partnership Health Center (Missoula)
  • PureView Health Center (East Helena)
  • Riverstone Health Center (Billings)
Contact Information:
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Phone: 406-451-7060

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Questions?